Tab 5

IN THE UNITED STATES DISTRICT COURT FOR THE
DISTRICT OF MASSACHUSETTS

In Re: PHARMACEUTICAL INDUSTRY	MDL DOCKET NO.
AVERAGE WHOLESALE PRICE	CIVIL ACTION
LITIGATION	01CV12257-PBS

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ALL ACTIONS

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Wednesday, July 20, 2005
8:00 a.m.

HIGHLY CONFIDENTIAL DEPOSITION of GREG KEIGHLEY, held at the offices of 875 Third Avenue, New York, New York, a Certified Shorthand (Stenotype) Reporter and Notary Public within and for the State of New York.

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medications not given intravenously, all given at a pharmacy?
A Yes.
Q What were your responsibilities as a manager?
A At UCB I had a defined group of reps in the district that I would oversee. I was the LA Orange County District Manager. It changed a variety of geography, but in that general area.
Q Other than the job you just described with Russ, Whitbey and UCB, which was one company that just changed name over time --
A Yes.
Q Did you have any other work experience, besides your work employment with BMS?
A Clarification it was Whitbey, not Whitley.
Q I understand.
A No, that was from '89 to '98 and then I picked up on this job in '98. So there

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was no gap in between employment.
Q Have you ever reviewed the complaint in this case?
A Reviewed the complaint, can you clarify "review"?
Q Have you ever seen the complaint in this case?
MR. TRETTER: Do you know what a complaint is?
THE WITNESS: I need clarification.
MR. TRETTER: The complaint is a pleading. In this case it's a big thick document that outlines what the allegations of the plaintiffs are.
THE WITNESS: No. I have never seen the document, nor have I had purview to it.
Q Can you tell me what your understanding is as to what this litigation is about?
MR. TRETTER: If you have some

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understanding separate from what your lawyers may have told you, you can testify. If it's based on what your lawyers told you --
A My understanding coming into this proceeding?
Q Yes.
A AWP concerns in a timeframe, earlier than now, that included a group of drugs and another terminology was it was a suit with a variety of companies involved, and that was the take-home message in that. I wanted to find out where I fit in. So I wanted to find if I was named as a defendant or an auxiliary figure, and I was told I was not directly tied to this and that was my understanding coming into this.
Q You said it concerned AWP. Did you know coming into this what the concern was with respect to AWP?
A No.
Q We'll talk about your call on your accounts. I know you testified earlier that you

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tried to conduct a full office visit, I think you called it, where you meet with various professionals in the office?
A Yes.
Q What sort of information, speaking in general terms, what sort of information do your customers ask for when you are calling on them?
A It depends on the actual or the specific interaction. Sometimes they will have specific questions of me and I will answer them to the best of my ability or have them sign a form if I don't know. You don't bluff when you're talking to physicians or professionals. So I have them sign a form, and I get that information from the medical services. That's an occasional time where I get a call from an office saying we need this.
It's usually the other way around, where I initiate a conversation about the drug that I'm promoting, and questions will evolve from that. It's always clinical based.

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Our company has always been one that wants to promote our drugs with clinical data and that's what I am given as our basis for presenting to offices.

Q What about your customers, do they inquire about the cost of the BMS oncology drugs you are promoting?

A Infrequently.

Q How infrequently would you say?

A If I have a hundred interactions, it might come up two or three times of a hundred. Most physicians are interested in how your drug works, will it work for their patients, and they're focused on what's best for their patients, and that's what I try to focus in on with my offices.

Q You said it would happen two or three times out of a hundred. Do you recall specific instances where you have been asked about the cost of the drug you are promoting?

A I'll give you some generalizations, and it's usually a statement

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that they're making. Wow, that seems like a lot of money or that seems to be a costly entity. I have to say it is what it is. You can talk to other people about it, but I'm the person promoting the drug, and I didn't make pricing decisions.

It's usually a statement of they see it as a high cost, and it's nothing I can combat. I have to say neuroagents cost more, and if they have a concern to possibly talk to somebody in the department that might be able to ease their concerns. There's nothing I can do when that happens.

It's usually a statement of concern, but ultimately in most instances they know that, you know, what, if I have the right patient and they run out of clinical options, it is an option. Most doctors come around to what is best for the patient. That's how we typically end a conversation, you know what, your drug is an option if I have a patient in need. I try to do right by the patient, I

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think most physicians do the same.

Q The rate you gave me on cost. Is that generalization over your entire career at BMS. Has it been more frequent in previous years, or has it changed over time?

A It's changed over time. Our new entity Erbitux is a costly entity, it's a biologic. It's not chemotherapy. We're for the first time in a biologic area, and those costs are much higher than traditional chemotherapy. So it's been the last two years that I have heard this, "cost issue" come up more than before.

Q Do you have access to BMS pricing of the drug your promoting?

A They tell us a per vial count, whether it's a hundred milligram vial, we have, you know, an a idea what the drug costs. It's not a major focus of our interactions with physicians.

Q How is that information disseminated to you, is that done -- well, let's leave it at that.

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How does pricing information get to you?

A Sometimes there's updates. Companies usually have a price increase in January and they'll give us what the change has been for our current drugs in terms of -- most likely it's a hard copy.

That's how I remember receiving years back. We do much more on E-delivery of things, electronic documents, that show there has been price increases. We're told if there are price increases, if your account has questions, please have them call their distributor or OTN. They don't want us fielding these issues commonly. They feel that's not our job to be dealing with that.

But, usually, we get a "yearly update" because that was the nature of the business that there would be a price increase and they would let us know that for our own sake of understanding.

Q That information would come to you

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knew they were physically at a location I could contact. And it was basically this account has a problem, Amy could you call them and try to -- I didn't want to get intimate with the problems that OTN or any issues OTN may have with a customer. That was not my job to clarify those issues.

I was helping out the organization by letting them know there was an issue, please get in touch with who had the issue and try to resolve it.

Q Do you recall what the issues were that caused you to refer them to OTN or speak to someone within OTN?

A Problems with the LYNX machine, delays in getting orders, generally you get 24 hours turnaround on an order, and offices rely on that turnaround, misorders, you know, it usually was around the delivery of drug to the office was the concern.

Q The physical delivery?

A Physical delivery, got brand B

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instead of C. We thought the machine was ordering A, we got B. Those types of issue.

Q You said the other resource you would refer your accounts to who had questions about the price of BMS drugs was Procert. What is it Procert?

A That's a program delivered by a company called Access Med. They have a variety of -- I think they deal with multiple companies. But in our -- we have labeled this product called Procert which is a reimbursement assistance line. All the companies have something like in in place.

They have two different functions. One call in number is for access to drug if a patient doesn't have insurance, try to get them to call for things. It's a variety of things, did the patient have insurance, and they're interested in trying to get a patient on drug, they call one number and that was -- they call that the RAP, Reimbursement Assistance Program.

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Procert is a product that once you used the drug and you're denied from an insurance agency, then they would assist in the claim. Did they not mark a box? Did they do something wrong?

And the Access Program was for patients, indigent or otherwise, that fell through the cracks, and their insurance wouldn't allow them to get the drug. They could possibly seek that as a therapy to get the patient on therapy.

Q One of the purposes was if an account was -- if their claim for reimbursement was denied, Procert would help them with the appeal of that decision?

A Yes.

Q If a client had questions about some aspect relating to the reimbursement for an oncology drug you promoted, what was your response to questions related to the -- we've talked about costs. I want to talk about reimbursement.

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Did customers ask you about or have questions about the reimbursement available to them for the drugs you were promoting?

A As a rep I cannot guarantee the reimbursement of a drug. That's out of my purview, and nor have I ever been asked to do that.

Any questions on reimbursement we are asked to pass it on to Access Med and deliver a number that seems applicable for that particular patient, one of those three, Access, RAP or Procert. Depending what I heard from the office, if they got the wrong number for the patient they could get referred to within that call system. It was one company delivering the three programs. I personally would make no commitment as to the drug. It's not my job.

Q You said you make no commitments. Did you have conversations with your customers about reimbursement?

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A If they brought it up, yeah. I wasn't proactive in that. I would try to respond adequately to anything the account brought up to me.
Q Can you tell me, in general terms, what were the concerns that you recall concerning issues of reimbursement?
A I could give you general, maybe comments made to me.
Q Sure.
A An office might come to me and it could be a nurse, even a doctor might come up to me and say I have used drug A in this tumor type, I'm very happy with it, I have a patient with tumor type B, I have never used it in this setting before, you know, what are the chances, what is the ability to get this paid for or covered for this patient B. And I would state to them that falls outside of our indication or label or whatever and I can't -- there's no guarantee, but what you need to do is call Procert or actually it would be RAP, this is

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where they're thinking about putting a patient on and RAP would get all the information about the patient and discuss with the doctor, you know, yes, you have -- there's enough data to support the clinical decision or there's not. Those conversations I'm not privy to. I never get updates from Access Med. They consider that privy information.
Now a doctor, I might on a follow-up call say, did you call RAP? Were you pleased with the response? They may say, hey, my office rep called RAP, and patient B is on the drug and that might be a wonderful success story. And sometimes they would come back and say there's no data to support it, they said we were going out on a limb, and it was a good chance it would be denied and not covered. So we're not putting the patient on it. So that would be a fall-out consideration.
Q What you are describing is a situation where the client had questions about their use of a particular drug would be eligible

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for reimbursement?
A Right.
Q Did customers ever have questions about the level of reimbursement available on the oncology drugs you were promoting?
A I don't recall.
Q You don't recall. I want to clarify that answer. You don't recall anyone ever having such a question?
A I guess my question to you is: What do you mean level of reimbursement? Define level.
Q Did a customer, anyone at any of your accounts ever ask you, for instance, how much they could get reimbursed for the use of a particular drug?
A Maybe a couple of times, a handful of times.
Once, again, this issue as a whole only came up very infrequently, and that specific instance maybe even with less frequency.

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Q Do you understand how the mechanics work? Do you understand how the oncology drugs you were promoting were reimbursed by the various segments of the healthcare industry?
A I have a general understanding of the issues at hand, yes.
Q Can you give me your general understanding of that issue?
A Once again, you like an A to Z to see how a doctor gets from one issue --
Q Let me break it down. If a patient is on Medicare, and the drug is covered by Medicare Part B, do you understand how that drug is reimbursed by Medicare Part B?
A In terms of AWP as a starting point?
Q Yes.
A I'm familiar with the steps you get to a bottom line number, yes?
Q Can you tell me the steps as you understand them?

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A As I understand -- it's not current way it's happening -- but AWP is a starting point. They get reimbursed at a level of AWP, which in the recent past was 95 percent of AWP, and that gives you a dollar figure after starting AWP times .95. And they get 80 percent of that number which is an allowable, and then the final 20 percent is secondary insurance or patient co-pay and that's my general understanding of how that works.

Q Do you understand how the reimbursement works if the patient is privately insured?

A That is a little bit more gray area to me.

Q Do you know if AWP is used as a starting point in the allowable reimbursement amount for the drugs you are promoting?

MR. TRETTER: The private insurance?

MR. NOTARGIACOMO: Private insurance.

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A I'm only going to give you a generalization because that's how it was brought to me. Typically, private insurers will follow Medicare's example, and that's my understanding, that it would be a format very similar.

You know, from Blue Cross, Blue Shield, I never knew the specific calculations. I didn't bother myself with that. I tried to keep a general understanding that this format played a part in the majority of cases. If you told me XYZ insurance company how did they do it, I couldn't tell you.

Q How did you come to this understanding that you just explained to me on the Medicare side and the private insurance side?

A At meetings and such. They wanted us to be aware of how our accounts deal with this issue, from just an awareness standpoint.

Q Can you remember at what meetings this issue was discussed?

A Not specifically. I can only give you generalities. That it would probably be at a

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regional meeting scenario, and then possibly at a district meeting, which was a smaller group of people to just go over this.

Q Do you recall any specific regional meeting where this was discussed?

A No. I have been to 20 plus meetings, and it doesn't stand out as an issue at a meeting. It was a half-hour of a three-day meeting type of thing. One or two meetings might have dealt with this. It was an inconsequential portion of the meeting and the dissemination of the meeting.

Q Can you recall, other than the general outline that you gave me, can you recall what else was discussed about this issue during the half-hour meetings?

A No, I don't recall.

Q Do you recall whether there was any written material disseminated at the meeting concerning this?

A I can only -- once, again, just a generality, I don't specifically know of an

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instance. But at these meetings you're reviewing Power Point presentations and a portion of meetings you get a hard copy for your educational purposes. That's generally how it's written out to us.

Q Did you ever keep copies of things given out at regional meetings?

A Not always. I keep it in a hard file for some time, and I go through and look at stuff. And if it's not applicable to current products or what my educational needs are at the time I throw it away. I don't keep every piece of paperwork. It's just cumbersome.

Q Searching for documents responsive to this case, did you search whatever copies of the regional meeting material that you had in your possession?

A I went through every subcategory of file and looked for anything that appeared to have the resemblance of information requested of me, and looked at the whole body of work, and if there was anything that had a slight mention of

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AWP portion was almost an after thought. It seemed to be like the back of the book type of thing. Offices and doctors could know, can I use this drug. I think that's what they use this for. Can I use this drug with this tumor? Is there enough data to support my clinical decision to use this, and that is what they use it for.

And, by the way, there happen to be some AWP on the back. There was some designation to AWP, because I think that was kind of the uniform or universal number that most people used. This was a third-party organization.

Q Was there other pricing information, other than AWP?

A No.

Q Other than this pamphlet the ACCC pamphlet, other than that, did you have access to the AWP for the BMS oncology drugs you were promoting?

A Our company would give us updates.

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As I said, typically in January there would be price increases, and we would get something saying the following drugs had a price increase. That was for our own, again, our own edification. But if a company had a drug increase we could say, yes, we did. Call OTN as to what your price is. They felt that that was an appropriate level of information to know.

Q When they were giving you an update on the price increase, did they provide you with any change in the average wholesale price of the drug, AWP?

A I don't recall.

Q Did you understand that there was a difference between the reimbursement amount available to your accounts for the drugs that you were promoting and the price that they were paying OTN or some other source for those drugs?

A Did I realize there was one number and then the number that they got -- what they paid for what was one number and what they got reimbursed for was another?

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Q Yes.

A Yes.

Q Did you have a name for that difference?

A I have heard the word margin used.

Q Is that a term or word you used to refer to that difference?

A In what setting?

Q In your job as you made sales call on your accounts?

MR. TRETTER: Are you assuming that's come up? You have a foundational question.

Q Let me back up. In what setting have you heard the term, that difference we have been discussing, called the margin?

A In two different settings. The doctor might be proactive. And as I said this is so infrequent that I could count on my hands in the years the times the doctor has used the term.

They might say what is the margin? And in the Bristol-Myers setting,

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strictly without customers around, we would be told there is a margin to drug. That being said, it was in my job description and told to me on more than one occasion that that issue is not to be discussed with physicians. It was something where they -- if that came up and it certainly was something where I had to be reactive to because I wouldn't bring it up to a physician. That wasn't my essence of why I was making a call to a physician. I'm discussing clinical information.

If they brought this issue up to me that's where I would have to utilize the matrix team, OTN, Procert if that seemed to be -- or Access Med, I may use that as a general term. It had a variety of subsets to it.

I felt it was something where I didn't want to get into discussing that issue. It got me off of the course of my clinical discussion, but it would occur and occurred very infrequently, a handful of times where a

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doctor that was their issue at hand. And they were proactive in terms of asking me. And, you know, because I was told it was something I should not be handling it was a pass-off type of thing. You know, call this number, please, and they can deal with this issue. And that's how I was asked to disseminate information.

Q Did you ever, when you were asked by a doctor, what is the margin, did you ever provide the doctor with a calculation of the margin on any of the drugs you were promoting?

A To the best of my ability, no, I don't recall doing that.

MR. TRETTER: To the best of your recollection?

THE WITNESS: Yes, sir, to the best of my recollection.

Q Do you ever remember seeing any materials, not talking internally, I'm talking about your interactions with your customers, any calculations of the margins on any of the drugs that you were promoting?

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MR. TRETTER: What distinction are you drawing?

Q You drew a distinction. You said when I asked you the question, where did you hear the term margin used.

You said, one, the doctor might be proactive and ask you the margin. And, two, you said, strictly in a BMS setting, without any doctors around there may be some other discussion. I'm not talking about the latter I'm talking about the former.

MR. TRETTER: What was the question then?

Q The questions is: Whether in any of those meetings where the term margin might be used or the concept of margin might have been brought up, did you ever see any calculation of what the margin was in any of the drugs?

MR. TRETTER: Did the witness put pen to paper, is that the question?

MR. NOTARGIACOMO: Whether he ever laid eyes on any sort of calculation.

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MR. TRETTER: Like the doctor doing a calculation?

MR. NOTARGIACOMO: Any way.

A I don't recall a scenario such as that where a doctor was -- it never seemed to be an elaborative event. They would say, what is it. I would pass it on and say I make X number dollars on this one and drug B is this. That just never -- I think doctors were cautious about this. This might be a discussion with colleagues but at a rep level they're very cautious of having this discussion. I don't think they want to want be seen as people that base their clinical decisions based on the money they make.

I can only hypothesize it happens at different levels. At a rep level they would make a statement and I move it to an issue where I felt I could answer it in a way, that please call this line if you have a question, and I try to move the question on.

It's outside of my ability. I would told -- where my interaction was with the

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physician, try to get them on with the clinical information and the issues of the drug itself and you know. Those decisions, as far as AWP, that had to be an issue the doctor dealt with. It wasn't my job as a sales rep to try to get them the answer right there. I never told them this is what I do on this drug, I just don't think that ever occurred.

MR. TRETTER: Let the witness the witness was drawing on a napkin what didn't upon calculation with spread, margin, things like that.

Q We have been talking about this in the context of discussions with doctors. You said earlier you made whole office calls, and you had meetings with doctors, nurses and, I believe, some of the business people in the office.

A Sure.

Q I want to ask the same question with regard to the use of margin or the concept of a margin with not just the doctors, but either the nurses, and/or the business people in the

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interface with.
Q Has that person been the same over time?
A It's been consistent over the last 18 months. This is another thing that was brought to my attention or not. I don't know if this person is continuous at the position since two years ago. I can't tell you since Erbitux we were made aware this person is our contact.
Q What about the marketing advisory group, do you know if that entity goes back the entire time?
A I don't know. It's only a guess to say there's something to that effect.
I know there's a marking group, that meets together. I know legal goes to it. From a hierarchy sense of things, from a rep sort of things, there's always representation at the meetings.
Q I'm asking whether the advisory group itself has existed going back in time?
A In some form or another whether it

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was always called the advisory group, there's some function in place that a group meets and goes over issues.
Q Other than the person you couldn't remember who is a sales rep, can you name any other members of the sales marketing group?
A No, I can't.
Q Is there an advisory group that deals with issues related to reimbursement that you know?
A Not that I am formally made aware of.
Q Is there anywhere that you are aware of that has a list of the advisory groups that exists now or that existed in the past?
A No.
Q We've touched on this subject previously, but I want to go over it in more detail. What were BMS policies, if any, relating to the discussion of the margin that we have been talking about with customers?

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of.?
MR. TRETTER: If any, first of all is there any policy?
MR. NOTARGIACOMO: Yes. Was there any policy at BMS concerning whether to discuss issues related to reimbursement, let's start with that.
MR. TRETTER: With an office?
A Can you -- a formal policy such as a mandate marketing.
Q I won't characterize it. Was there a policy that you were made aware of that related to, in any way, the discussion of reimbursement issues with physicians or their offices?
MR. TRETTER: Can you answer the question.
A With the clarification we had a program called Practice Efficiencies. And that wasn't a direct discussion of margin, but that could be characterized as something that fits the area that was brought down from the ADBAs. We

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had a program called Practice Efficiency.
Q When a say "program", what do you mean program?
A It was something we were made aware of at a meeting, and it was something we could possibly use in an office if needed to or -- it was left at our discretion. When they give us a marketing plan, they give us a variety of things to utilize and it's the reps' discretion to use any and all of it. It depends on the office.
Having a lot of things at your disposal allows you to pick and choose what is appropriate for the office. It was a small program that lasted four, six months. And it was over all termed a Practice Efficiencies Presentation.
Q How was that material presented to the sales reps?
A Once, again, at a regional meeting, PowerPoint presentation and there may have been a subsequent district meeting to go

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over the information again, but at least once it was presented to us.
Q This Practice Efficiency Program, do you know what department at BMS created this program?
A I can't say who created it. I can say who disseminated the information came from that Associate Director of Business Alliance, that was the division that gave the information to us.
Q You said the Practices Efficiencies program lasted four to six months, do you remember the time period?
A That's around 2000, 2001. And I can't give you an exact timeframe in terms of the length of when it first started and when it ended.
We rarely get defined end points in terms of stop discussing an issue. We're always told this is our marketing plan, but that doesn't mean you can't use information from a prior marketing plan. There's no finite

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stops in terms of a discussion from a final issue.
Q That leads me to the question. You said that the program lasted four to six months, what does it mean "the program lasted", does that mean the program is no longer available to you?
A No. The emphasis and interest waned. It went away and it was no longer -- when you get a marketing plan your manager in your discussions and work sessions will say are you implementing this speaker program. When the speaker program series comes up, and all the events have taken place, then that's not an issue with your manager.
This had a defined period of where she would ride with you, and if I were implementing this and she would suggest and she said ideas of may be working with your accounts, maybe you could utilize this bit of information. And at some point in time she stops mentioning it, and, you know it's gone by

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the wayside. You forget things, things you don't know. You forget you have access to them and they go into oblivion.
Q Was there a policy decision made or are you aware of any policy decision to stop using the information that was presented in the Practice Efficiency Program?
A I don't recall any substantive -- I only used it a handful of time, couple of times, I don't know why I stopped doing it. It was something specific the company provided me that made the emphasis in my call or change in my call. I can't recall -- we're not doing this type anymore -- that rarely, rarely happens.
When do get things where the FDA has deemed a piece, there's a wording that they caught and we have to cease and desist using it, and we throw it away, and we get a new one with the wording. And this is the only time we get the finite pieces and stop using it and it's usually an FDA mandate where they say you're not to use it, throw it away. And we

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don't get that from a company aspect, stop talking about this, they just highlight new things to start discussing.
Q I know you said 2000, 2001 they made this PowerPoint presentation, in what context? What sort of meeting?
A At least at a district meeting it most likely was at a regional meeting.
Q To the best of your recollection, can you recall whether it was 2000, 2001?
A It's a guess. I don't know. It either happened at the last POA of 2000 or one of the first of 2001. I don't recall the date.
Q Was it one person who made a presentation about the program?
A In terms of an initial presenter I can think of one person.
Q Who is that?
A Irene Paulin. How many people were involved in this program, I don't know. But that's the only person I recall disseminating the information for the first time.

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that was the only time --
MR. TRETTER: Of your recollection.
A Recollection, sorry.
Q And never occurred before that?
A Not to my recollection.
Q Were there ever any discussions about whether or not to discuss reimbursement issues with your clients prior to the institution of the Practice Efficiency Program?
A Can you state that again.
Q Were there any discussions at any meetings internally at BMS where the issue of discussing reimbursement issues with your doctors came up?
MR. TRETTER: What he's asking is, now he's getting to the policy question. Were there any rules, regulations thousand shalt never discuss reimbursement with your customers by the powers that be?
A I think there was a general

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statement that, this is not the essence of your call that you are never -- you should not make it your focus to bring the subject up. This should not be the first thing out of your mouth. There shouldn't be a proactive setting until you are reacting to a situation or scenario where the doctor is making mention of something where they have a concern with.
We would never go in on an account with the sole purpose or even the purpose of bringing this issue to the forefront.
MR. TRETTER: This issue being reimbursement?
THE WITNESS: Yes. This was not our function, our call to duty. It was always get back to the patient and get information the doctor needs to treat the patient. That's our sole function and that in being a person who can hopefully, if an account has a concern get them to the right person in the

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organization. This was a tool, one of many that we had access to.
Q When you say "this", what are you talking about?
A The Practice Efficiency Program was a tool that was given to us. One of many and nor was it asked of us to make this the primary reason or focus for a sales call for any reason.
Q You said there was a general policy that discussion of reimbursement issues was not to be the primary or first focus of your calls?
A Right.
Q When you said that, were you talk the time prior to the Practice Efficiency Program or the time up to and including --
A This was never, to the best of my recollection, we were not to be proactive in our discussion with accounts on any sub-issue associated with reimbursement. That has never been a focus -- or they wanted a percentage given that 50 percent of your calls to be the focus --

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there never was any delineation as to that. We were made aware this issue can come up, this is how it comes up and this is how you deal with it. Use your matrix team, use the people that have the auxiliary functions to help them, that's how we were told to function.
Q Where were you told to function in that way?
A A variety of ways, district meetings, every business unit had its presence at meeting. You had legal there, the medical services department that talked about medical issues, you had all these divisions of the company that you knew they had time set aside for at a meeting to discuss what they were doing. You know it existed within the organization. They told you these are the issues we deal with, if they come up have your account call us. It's a way of doing business over time. It's never changed. The people responsible have changed, but the divisions have been there, and we knew we could call them up if we had an issue.

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doctors.
I asked for additional examples and he said as qualified by very sensitive, I would say no, but there made have some who made comments. I asked him then who made comments. Let's not be so narrow, let's broaden. You brought up the fact that there were two practices where he used the efficiency program. And I wanted to speed things along, so I exempted them out. And then I asked who else may have made comments other than the four either practices or physicians we have identified so far.
A I need to clarify. There are a lot of quips that someone can say when you come out with something. And this is getting to a timeframe that I think is out of the analysis because our drug Erbitux is not in the realm here. I didn't get wow, that's expensive. That terminology didn't exist.
It's a very infrequent amount,

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that's the sum total of doctors in essence of what we're discussing timeframe-wise that had any portion of a conversation that might allude to this. It was, you know they make general terms, cancer therapy is getting expensive. You might say the doctor is sensitive to drug costs, but I can't say it's just my drug.
Cost is an issue and I could say in seven years of time, maybe half of my doctors have made one-line sentences relating to general issues. So for me to point out four years ago this one doctor said this one thing, I don't think amounts to anything in terms of what we're trying to discuss.
I had two doctors that standout in my mind; one was a hearsay, one was a doctor coming to me. That was literally two times of hundreds and hundreds interactions. We're talking a snippet, snippet of time. That they're brought to the surface in front of me which is the only thing I can discuss.

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Exhibit Keighley 004. You review it and tell me what it is.
A This is one document, a PowerPoint presentation in its original form. That was called a practice efficiency, that's how it was presented to us. This is a workshop at a regional meeting and it was presented to a group of reps and managers that were attending this meeting and then we got a hard copy associated with it, either at the meeting or sometimes afterwards.
Q Would this be the PowerPoint presentation given by Irene Pollin or something different?
A This she was involved. I believe she gave the initial presentation to a group of people, yes.
Q When you received this copy, either electronically or in paper – did you receive it in electronic or paper?
A I don't think that was the first transmittal. I think we had a hard copy in front

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of us at a meeting that we could go through and take notes on and see it in front of ourselves. I think the first way that we got this was a hard copy.
Q Subsequently you received a hard copy?
A At some point after the initial presentation, yes.
Q Did you see anyone else besides Irene Pollin give this presentation, you indicated she had given the initial presentation. Was there a subsequent presentation?
A Not of the same material. There may be references made by other individuals regarding this, but not another rehashing of the information.
Q Am I correct in this information, this form, is not a form that you would have had -- is this something you would have shared with your accounts or was there another document that was produced as part of the Practice Efficiencies and Quality Care Workshop that you

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would leave with your accounts?
A This was a stand-alone presentation that we would verbally give on an account. If they're taking notes on the side about it, that's their own doing. I didn't physically make copies to leave off with the office. This is such a general kind of overview, it was just to bring the thoughts to the audience and that was it. There was no leaving off of forms and utilize this form in your office. That was not the essence of the program.
Q Was there any written information that was part of the Practice Efficiency Program that you were provided to leave with physicians?
A I don't recall.
Q So you don't recall whether that ever existed?
A I only can surmise that in the one or two instances where this may have happened in my territory, I did not physically leave off these items, nor was I asked to leave off information.

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Q Can you turn to Page 2 of that document. There are a number of bullet points there that seem to indicate differing years.
Do you understand what is being portrayed there, 1990, '94, '99 and '02.
A It's a historical background of how doctors were reimbursed. In 1990 it was AWP plus a percentage, in 1994 went to AWP. It's a historical perspective. 1999 it went to AWP minus a percent, and this is happening some time in 2001. I assume this was put together in 2000 because we're referencing 2001. We don't know when this is going to happen. This is some time in 2000, we don't know as an industry where things are going.
Q Do you see how, I guess it's the right-hand side, it says "co-pay 20 percent" and then in larger numbers "co-pay 20 percent" and in each successive line it gets larger and larger. Do you know what is meant to be conveyed by the increasing font size?
A I can only guess the intention of

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the presenter here is the co-pay becomes a larger component as time goes on, on how important it is to get that collected. That's the only assumption I can make.
Q Can you turn to the page that's entitled "Net Revenue Factors", which is Bates numbered 2309?
A Okay.
Q You see there are four different bullet points under collection rate?
A Yes.
Q The second and third are percentage charge versus reimbursement and reconciliation colon co-pays. Do you know what the reference to percentage charge versus reimbursement is?
A Not right offhand. Percentage charge is something that is not in my lexicon. I'm not sure what that is a reference to versus reimbursement. That is a foreign concept for me.
Q The next says, "reconciliation colon co-pays". Is that an indication that

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co-pays are an important part of how the revenue, an important factor to consider when considering revenue of your clients?
A Well, it's under the category of collection rate. It has to do with the collection rate of co-pays, beyond that I cannot answer.
Q Can you go two more pages in, it identifies five key terms and one is, Average Wholesale Price and it says, calculated by pricing companies, i.e. Red Book, Medi-Scan and First DataBank, accounting for distribution and overhead costs."
Is that a definition of average wholesale price that you had seen at BMS any place other than this presentation?
A Verbally I heard of Medi-Scan, Red Book, and First DataBank, but the terms weren't significant in terms of hearing it on a daily basis. I was aware of those terms as being major third-party organizations that provide the data. That's all I was aware of, that they were the

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source of the AWP, beyond that I didn't have a familiarity of what it meant, how it was derived.
Q Putting aside the parenthetical reference, had you seen the definition otherwise –
A No. Not with that terminology, no.
Q Do you have an understanding today whether that is an accurate definition of average wholesale price?
A I don't know if that's the correct one. I would understand that average wholesale price meant AWP. It never went beyond that. My personal understanding is it was a term -- it was what it was. And I didn't seek greater understanding and no one disseminated any greater level of knowledge of AWP to me.
Q Turning to page Bates numbered 2312. Top bullet point "Most payers use AWP as a basis for calculating allowables, is that consistent with your understanding of how AWP is used?

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A At that time or currently or always?
Q If you have a different understanding over you can tell me?
A Over time that's my understanding, yes.
Q Can you turn to the page, "Medicare Allowables Taxol," Bates 2315. When you presented the Practice Efficiency Program information to the two customers that you testified to earlier, did you go through any of the numbers on this page or the next?
A Not specifically. I can't recall the specific need at the time. There may have been greater emphasis on one-page depending on the audience. If I'm talking to billers, I'm not looking at this page. It depended on that moment in time. I wasn't told I need to spend 10 seconds on a particular slide. I can't answer the amount on emphasis I gave this or if I skipped over it. There was no format I was told

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to give the presentation. This presentation was to help the needs of the office, and if they said oh, this is interesting, I would spend time on it. Oh, I didn't know AWP -- it was tailored to the needs of the office.
Q I'm asking you, specifically, what your recollection is?
MR. TRETTER: Sitting here today, do you have a recollection of going over this page?
THE WITNESS: Not specifically, no.
Q Would you agree with me looking at the math, and I can walk you through, it says Medicare pays 80 percent. That's represented, and this is for Taxol $138.80 and it says OTN cost 131.70. If one of your accounts was purchasing Taxol for 131.70 and was being reimbursed from Medicare for $138.80, the margin just on the 80 percent now was $7.10 to the practice group.
MR. TRETTER: Just on those two

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numbers.
MR. NOTARGIACOMO: Yes?
MR. TRETTER: Not on anything else?
MR. NOTARGIACOMO: Taking one number and subtracting the next.
A Yes.
MR. TRETTER: That's mathematically true.
Q You would agree, would you not, if the co-pay were to be collected by the practice, a co-pay of $34.70 would greatly increase the margin available to the practice group on that particular administration?
MR. TRETTER: Objection to the form.
A The analysis is the analysis that the co-pay is something they're suppose to legally bill for. It's part of the equation. It's 20 percent -- those numbers are there. There is not slight of hand. Yes, the co-pay is $34.00 and yes, if you take a baseline of $7, and

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add $34 it goes up. It is what it is.
Q Collecting the co-pay was important, at least in part because in this instance and in this example, the entire co-pay was added to the margin available to the practice?
MR. TRETTER: Objection to the form. Based on the looking at only these numbers, you collect 34.70 more than you would collect if you collect the co-pay. The question is margin can take into account lots of other things, services, waste, storage. It depends on lots of things.
MR. NOTARGIACOMO: That is not to be debated here nor determined. I'm simply asking the question about the $34.70, the $34.70 is in excess of any amount paid for to OTN by the account.
MR. TRETTER: My problem is: You want this witness to do something to buttress your case as opposed to

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reading the document.
Objection, the documents speaks for itself.
Do you have question about the witness' knowledge as opposed to use him to bounce the document off of, go right ahead. This seems to be, at this late hour, not an appropriate line of questioning.
MR. NOTARGIACOMO: My deposition. Can you read the question back I asked before.
(The requested portion of the record was read back.)
A It's an analysis that a co-pay is a co-pay. They are demanded to collect a co-pay, I can't add anything beyond that. And if you add 34 to seven yes, it's more than seven. There's nothing more I can state about that.
A co-pay is part of the equation in this analysis. It's part of what they do. They collect co-pays. They have secondary

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insurances. It's a function of how business is done, and I don't think I can comment any greater than that.
Q Turn to the next page Medical Allowables, Paraplatin, and quickly going through the math, Medicare pays $88.89, it's costs an OTN customer $89.83. Which means just accounting for the Medicare payment of 80 percent, the practice would loss and that's all they receive, they lose $1.06?
A Yes.
Q If they didn't collect the co-pay they would be out of pocket $1.06?
A Yes.
Q Can you turn four pages more to a page entitled, Physician?
A Okay.
Q Actually turn to the page before that Practice Efficiency Model. Can you tell me what the bottom entry is, "BMSO Partners 100 percent guarantee for greater than 70 percent patients," what is that a reference to there, if

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you know?
A At this timeframe the partners meant OTN, Access Med, BMS, sum total. At that point in time the compendia listings for both drugs resulted to 70 percent of patients that come through the door, 70 percent could get the drug. That means 30 percent didn't have the tumor type where these drugs work. They fit in line with the drug usage met 70 percent of their needs.
And the 100 percent guarantee meant that if you used it for this 70 percent of patients you would get reimbursed because it had a compendia listing. That was a reference to a compendia listing.
Q The guarantee is if you're using it for the patients that fall into that 70 percent, you're going to get reimbursement?
A Yes. There's significant clinical data to support your decision with that 70 percent of patients.
Q The next page entitled Physicians.